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GUIDING PRINCIPLES FOR AN INTEGRATED WORKFORCE

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>> Are you doing team huddles at all or any case reviews? You can type in, speak out, we have all of the lines open, there is no one muted.

>> We're doing a team huddle prior to the primary care clinic every Tuesday morning for half an hour looking at who is scheduled to come in and any follow-up on the previous week's patients. We're doing a second huddle after the clinic to be sure that all the leads that were he'd identified in that time were addressed.

>> That's great. I have heard about the morning huddles, having one in the afternoon to wrap up, if we do that, that's interesting. Curious about providers that ask about -- that came up in terms of time and money, are they short huddles, 10, 15 minutes?

You may have muted yourself again.

>> Our morning one is a half hour in length and the afternoon is one that's not -- it is typically 10, 15 minutes.

>> This is with staff not seeing an individual patient?

>> Right.

>> Thank you for sharing that, your experience with huddles and that you're doing it. I think it is a critical element and

what we hear about folks that are trying to integrate different services that we see that is key, especially with obviously a patient population that is tough to engage and has lots of complexities. Like the folks you're serving. We have a few services related to team huddles on the website like what Jake mentioned, examples, how to have that conversation, and it is a great role for your base to bring in those skills around communications to be a success as a team to work as a team. A resource I mentioned earlier that I want to call your attention to, it is a paper we did talking about the elements of the team and really what my main take away here is for you around the role of leadership. You know this but it has to be top-down F you want the team to be successful, to feel engaged, they have to know that this is something that the whole organization is committed to. It is not just -- it is -- it is a way of the future, how we want to provide care to the people we serve as part of the larger vision. That really helps when trying to bring the teams together to do some of the tough work that needs to be done.

As you see here, some of the pieces, I mentioned the leaders, providers are given clear expectations, again, you know, that gets to why we think that the competencies, they're a powerful tool to sit down, think through, looking through it, who is responsible for what? Having clear expectations around roles and responsibilities is so important and as you sit down and think through how does the patient go through the process of enrollment, treatment, referral to specialty resources, being able to with every point in that workflow identify and be clear about who is responsible for that follow-up phone call is key. It is something to think about as we continue with the team. Looking at outcomes, we find that a lot of times people say I'm here for data for data sake, be it in this as a database, but how are we getting that information out, that when you're up loading to the system, how are you able to pull the reports and being able to show that, wow, look, our patients are improving, our team is effective, we're meeting goals and benchmarks. Anyone working towards being recognized as a patient medical center home? Some of you may already be a patient center medical home. For those of you that have not gone through the NCQA process, we have a ton of information on this if you would like to learn more. I just want to call out that team-based care, specifically the role of the behavioral health provider, it is explicitly mentioned in the requirement. This is a must-pass element. If you're doing patients in a medical home, and you have a team working on it, we talk about the role of behavioral health, HIV, prevention, treatment, the work that you're doing on this project, it can demonstrate how you are

achieving those measures. It is just a great contact for the fact that the work that you're doing, it is with other quality assurance projects, other criteria that's coming out from your state, so just something to think about. We have a lot of information about the NCQA requirements if you would like.

>> Recruitment, retention, key factor is recruitment and it is a good fit for the quality of care, thinking about that, that clinical social worker, who is now working in an HIV, AIDS treatment facility, that's going in and out of exam rooms, it is a different model. You want to think about who is a good fit. Again, I like the competencies, they help you, again, think about the job description announcements or for the team to communicate here are elements we find important as we do integration. That gets to the right person, gets them on the right bus.

Pardon me. Summer colds. Fun.

It gets it to the right people on the right bus and also how we think about monetary incentives and rewards. We will mention about the national health service corp. Certainly non-monetary incentives and rewards, really thinking about the development of the model, celebrating successes when you have a planned study activity completed and seeking through job satisfaction. There is good data showing for position, primary care positions that have a successful integration, especially with behavioral health where they're able to access that coalition, and higher satisfaction, when they're exposed to it, they don't really want to not be in an integrated setting, they know they have somebody to help when they have somebody in the exam room and they have somebody working out with the community with patients and where they live to help support them, a lot of good satisfaction we hear from teams. I don't want to undermine the point that Jake made around supervision and support, we have the great shadowing tool and other great practical tools as you think about shadowing and supervision, be it middle help clinicians, volunteers, peers, really important. National health service core, some of you may be familiar with this, I want to share it, it is a reessential, recruitment tool, people forget about the behavioral health component. Actually in 2013 I think it was there were over 200 psychiatrists in the national health service corp. Today the behavioral health clinicians represent more than half of all professionals in the loan repayment program. It is a growing area, I want to make sure that you're aware of who can be supported through the national health service corp. Thinking about the mental health, behavioral health, the licensed clinical social workers, counselors, they're licensed professional counselors and they may be trickier when you think about addiction counselors. This

is a certified list of folks and it is a great tool if you're not currently, check with your partner organization and if not, you want to seek that opportunity, there is some great opportunities and some things for you to think about as you think about joining national health service core. You have to be in this area or health professional shortage area, pardon me. And you will have paperwork. It is a great tool. Have any of you used the successfully this to recruit some of your team for this project? Curious.

Think about it as you go forward.

Obviously next, education, training. This is where I would love to hear from you, what do you think is the missing components or needs that you have when you think about integration in training needs.

You have to think about what training do we do when somebody is already involved in the service, on the job training, as well as certainly the work that we're doing to move ahead so that people coming out of grad school, medical school, other programs are already prepared.

You're asking what title you should see, it should be education and training.

Thinking about the current, future workforce, we're talking about the graduate level education for professional certificate and national training, I think there is a lot of growth in terms of online training both that offer continuing education credits and patient education on the model of care and cultural competency and adaptation, those are the key areas that you want to think about for your training.

I want to share some examples of training that we have helped and support, by the way, this is not exhaustive, there is a ton of material being developed out there. I would love to hear from you as we think about the different audiences and certainly adding on needs around your HIV/AIDS prevention staff and folks working on the treatment side. What are the training needs that you have seen with your patients? I'm sorry. With your staff.

Aaron, you're on the line, I'm curious to know what have you done or what do you feel challenged with around providing training.

>> What we encountered, we thought we were getting a diverse, an integrated staff so we had someone who is a mental health specialist, a social worker and a peer with experience and who is HIV positive, and we had someone else who had a lot of experience in outreach. We learned quickly what we were sharing with him, they're a team, they get together every day, they share an office, they were not very cross trained. We sent them to a lot of trainings together. Someone that was a mental

health expert, two others with her, they were not, they went to training together so they were cross trained and disciplined because we found it was too specialized in our workforce.

>> Just curious, what was one of the training that you sent them to? What's an example.

>> Evidence-based practice, the clear intervention, it incorporated all three of the strengths and motivational interviewing and they have been doing an ongoing virtual and in person training, those are two of the evidence directives we sent them to.

>> That's motivational, that's a great skill for our primary care clinicians to gain, to support them when they're directly working with patients. That's a great cross training opportunity. You want to make sure that you have this course but that ongoing practice, being able to have a behavioral health clinician that's trained in it, that's able to be confident and support other staff in using it, that's critical.

>> What about the behavioral health staff, have they needed additional training?

>> Yes. Yeah.

We focus more on a smaller team which has more of a HIV, hepatitis training and background. That's our next step, to get them more familiar with substance abuse training as well because it seems that's a lack, something that our consumer base really needs more help on and we thought it would be good if they knew more skills to be able to work with them right away.

>> That's a great point. Two things we hear commonly, it is the behavioral health staff needing to have education on basic health literacy, but now we're involving them not just in people and recovery in addiction and mental illness but in managing chronic conditions and medication so they need basic health literacy so that they can speak the lingo a bit of healthcare. Certainly around substance abuse and addiction, even though most licensed clinical social workers for example do get some training in addictions in schools 90% of them, you ask them, they're not prepared to really fully stretch themselves and need additional support. What can you do around the brief intervention, certainly you don't expect them to do robust treatments but it is a balance of you need extra training but also understand what's there and the needs of the population that you're seeing.

>> That's a neat approach to kind of figure out what is the general skills and knowledge that have to exist across the scene and then what's that foundational knowledge and then, you know, what are people more designated specialist areas. I'm interested to hear more from folks about how they figure out how they show the knowledge, how it should be and how they have that

knowledge and it looks like we have a comment from Amy who says that -- Amy, I hope you don't mind I'm sharing this. Our family nurse practitioner and partners are helpful in training medical providers and interventions in MI because the nurse practitioners are more open to the interventions -- more open to these than interventions that will take longer. That's one of the benefits and advantage of the brief intervention, to fit in the session that medical providers are used to having with people, they don't have the minutes to do the longer term intervention and in a lot of our brief interventions, we have found that peers, it is a great resource around MI and other intervention partly because I think for people who are really trained as specialists it is difficult for them not to move to the referral, the treatment piece, instead of really being able to support people in the middle that don't have a substance abuse disorder yet or you can do intervention and we have seen that some clinicians really struggle with that piece. Peers, they don't have to unlearn that specialist mentality. That's an interesting phenomena that we're noticing.

>> I'm going to go through a couple of these, then we'll continue to talk through some of your challenges and what you have been successful with around the workforce.

I want to make you aware, for those wanting to tap into psychiatrists to serve as a consultant, independent even necessarily providing direct treatment so if you're contracting with or have a psychiatrist that maybe is on this project to serve as a consultant to the primary care, you know, there is really good training both online and through the APA that supports them. If you want to make sure you have a psychiatrist consulting, that they have had some exposure to what does that mean to support a primary care physician as part of the team on medication management. And other aspects of managing care. We have access to now some really good psychiatrists and even available for one on one technical assistance. If you really want to access someone that's doing this successfully, just to have a phone call with your medical director or your psychiatrist we're happy to facilitate a one on one conversation. There is grit training. This is one of them around whole health action, how do we help support peers. Community health workers. HIV, AIDS volunteers, the support workers on how do I create that goal? How do I support that person's goal setting how do I do a weekly action, running a 6-group course, it is a nice course people can take to support them in that. It does offer some continuing education and it is for anybody. Thinking about behavioral health providers, what's it look like to work in a primary care clinic? I think of this even as if you're thinking about say you have staff over at the

behavioral health site that you want to go work now with at your partner organization, it is a great course to take, to understand what's that mean to be a part of a primary care team and help them understand if that's something they're interested in. Making sure it is a right fit for them. That way instead of picking so and so, a great clinician, we'll send her over here and now she's working in a totally different environment and different way and is unhappy and it is not successful. It is a great online course that's for free.

There are courses available with the tools of social work, these modules, what's nice, University are using them, they're available for download. If you have a strong team of social workers, you want to take the curriculum and build it in cross training, it is a great resource to take and access. Part goes to the health literacy things that I mentioned earlier.

>> We supported work at the University of Massachusetts around care management. This is an interesting challenge we hear from providers, how do we help people prepare to be care coordinators or managers and really thinking about what's that mean in terms of engaging patient activation, encouraging self-management, also how to handle that navigator role of referring patients to specialty services and being able to be there, available for patients, it is a good curriculum, available online, if that's something that any of your staff would be interested in taking. A newer one we're looking for, a modular website but we're waiting for the online course to be launched. This is training primary care physicians, be it physicians, nurse practitioners that are working with serious mental illness or addiction. What do they need to be successful in working with this population? There is special needs and understanding there. Even around the issue of trauma, how to make sure people are not being retraumatized as a result of engaging in services with us.

I would love to hear if you have accessed mental health first aid, when we work with them, this is great for their front desk base, this is GD for those with volunteers, it gives building the capacity and what's mental illness and substance abuse, there is a ton of community partners offering the free mental health for courses, it is an 8-hour course that you can go to or have a mental first aid trainer come to your organization. We see it from front desk, security, volunteers, it is a great community based training program F you go online, you can locate your kind of local community trainer if that's something that you want to follow-up.

Really this gets to what you brought up earlier, I think what it all boils down to. It is the essential of cross training. Be it population specific diagnosis and

characteristic, making sure that everyone understands the screening tools. Hopefully you're familiar with the HTQ9 or the 8 or other screening tools that may be needed. You talked about integrated vital, so making sure that our behavioral health staff understands, what we're tracking. Evidence-based practices, motivational interviewing. Team prospects, understanding how does the teamwork, what's that mean to be a part of the team and huddle. What comments we hear from behavioral health staff and to feel empowered tore speak up in a huddle around a specific patient, you know, maybe somebody recommends a certain treatment plan but the behavioral health clinician that worked with this client, maybe I understand that somebody may be revisited or have challenges or resistant in following the plan because of the environment or family and social dynamic. That's where we can be helpful in contributing to this. Part of that is the community resources that we have heard connecting and it is great we have heard in the discussion in the general discussion about folks that are accessing that.

Supervision, Jake mentioned this earlier, I want to bring you back to it.

It jumped -- okay. I would love to hear what kind of questions and thoughts has this generated for you about your project and needs of your team?

>> I'll allow people to unmute the lines. Amy has also shared that her psychologist partners, it is helpful for everyone on the multidisciplinary team with the social competence training specific to the LGBTQ population and that they're using the same language and it is fantastic. Has anyone else found that there's additional training needs perturbing to LGBTQ populations on the line or kind of going back to the one shared about the different cross training needs. Are there any of those that jump out to you where there are still growing edges for your team?

>> All lines are open. Feel free to jump in.

>> Someone wanting to offer a comment?

>> It may be interesting too to thinking it ahead of what are some of those really good trainings, either an online course or other training so if you could really use support with further education, that's something that a resource that we could think of creating or sending out to folks if that's helpful to you.

If so, feel free to type that in. We'll love to have it captured in terms of what training or resources would be helpful to you.

Under supervision, onsite training, shadowing, here is some elements of the tool that we posted around VHC, behavioral health clinician. An example if someone is shadowing, what are

things that you're looking for that they're able to be demonstrated by their colleagues or that as part of their performance that they're demonstrating. For example, does the behavior health clinician obtain information about an individual? Is it basically are they prepared? Do they read the chart? Do they participate in the morning huddle, the case conference? Can they describe as far as how they have encountered the patient, thinking about concurrent documentation, not just about behavioral health but all providers about you how do I successfully enter this JFK and also look up and engage the patient as part of that care. That's a training need and a nuance of cross training.

Certainly, is your behavioral health clinician appropriately triaging, seeking assistance from others and thinking about what to do when the BHC is unavailable to see an individual at the time of the request. You know, if you're screening and all of a sudden someone is demonstrating that they may be in crisis, what's the backup plan if your counselor isn't there to kind of provide some immediate support? Just thinking through what the options are.

Partnerships, this is huge for a lot of you that are partnering. We talked about the court ship and honeymoon. There are some things to think about around the partnerships. What that really means. What are root successes? Do you have a shared mission? What is the mission for you and your partner, what are you bringing back to the CEO, your board of directors? Common language, we see that just even understanding what is integration, how should I refer to HIV/AIDS, how do we refer to the consumers, clients, patients, this language matters. Just making sure that you're on the same page about language is important.

What I want to mention, about delegating trust. Creating empowerment.

We have seen relationships fail and partnerships ending in divorce, if you would. By not having enough trust in their team and each other. Everybody is there trying to do their best and nobody is purposely trying to cause harm but also up to the point where in developing shared solutions, we're available to come in if there is a solution, a problem that needs to happen. We have seen it where, you know, one person can be kind of a wrench, if you will, and we don't want that to happen. Being able to have leadership fully engaged in that partnership before it gets to a bubbling point, it is really, really key.

Here are some points that we want to share with you, to think about.

Think about your partners.

I would like to go to the phone line if there is anybody

that could share a challenge, a success they have had in their partnerships. Maybe something that worked well in developing a partnership as part of this program or developing a community resource.

>> This is Erin.

We had a great opportunity to partner with a local hospital and it took a while to get the foot in the door but when we were, they were gracious and great and we toured the facilities and we said we wanted more hepatitis care, specialty care, that's prevalent in our population they connected us to another hospital and went on tours, gave us essentially a number to reach which was hard for a lot of our consumers when trying to navigate a hospital, we now have a person to direct dial any time we need for their health with Hep C or a new diagnosis of HIV.

>> That's great. You have regular meetings with them at all, quarterly?

>> That's a great next step, we want to do a quarterly thing, it is more informal than that.

>> It is good to talk with their team to follow-up with the current consumers and care.

>> We see really small things making a difference just highlighting that in the newsletter, tweeting about them, well, they really do appreciate this relationship, giving them something that they can give to their board of directors or to their staff. Here is a consumer story, a client that benefited from this partnership if you would like to include in your newsletter or here are PowerPoints that you can share with the leadership team. Those are things that we heard stories of that can go a long way as well. Just to reinforce that partnership.

>> Great suggestions.

>> We had a comment in the chat box about training people on cultural, specifically the LGBTQ and training primary care providers on how mental health impacts overall health including if you're an indicator, I wonder if anyone on the line had resources that they would like to mention that you have found useful. Also feel free to type it in on the box too.

>> This connects directly to something that we're thinking about outside of a project of our center, kind of a slide deck we want to get a feel on the ROI, what's the return for investment on integration, we understand that the medical care team can be hard to convince. What is the slide deck of resources both the stats in terms of the comorbidity and patients are here and you think they don't have issues and we do, what we know in terms of good outcome when we do integrate also steps on satisfaction. A couple of research studies have shown the time that was saved by having the behavioral health

consultant embedded and then also one around physician satisfaction.

>> We're happy to provide that, we have this e-mail coming out next month. Anything you can get your hand on to make that case to educate them. Really it is connecting to another physician, we have physicians that are big proponents of integrated care and getting them all on one of your team meetings one day for an hour we're happy to facilitate that, let your GPO know that's something that you would like.

We have 8 minutes left before we head back to the general session.

This is thinking about the community-based coalitions working on intervention which is funded, if you don't already use them, I want to make sure to point out some of those opportunities to use the substance abuse coalition. It will support your local efforts. They had a lot of great data, if you're not actively engaged as part of this project, they may be a good partner opportunity. .

We'll end on leadership, this didn't work out very well. I think that the main point here with this one, it is just that collaboration of cross functions and how we can develop that cross-organizable learning capacity. We often think about workforce and training and recruitment and training, throws given. We often forget about the role of leadership both in terms of what are their needs and how do we support leadership p we think of managing up as well as managing down.

One of the things we suggested in terms of a changed leadership guide is how to create that future vision, how to reveal the current reality and think about promises for action and how has leadership -- this is where I want to get in six months, how are they providing coaching and support and following up on promises. There is a whole report here that we have available on the website. It is called leading healthcare integration. How can we support you as you try to work with your senior leadership team to try to manage up and get the change you need to be effective on this project and improving the care that you need.

We have 5 minutes left before we'll be automatically switched over to the general session. You will hang up from this phone call and dial back into the main line. In the next 3 to 4 minutes, what questions or needs do you have? What did you want to address that we didn't when it comes to workforce? Feel free to speak up if you have anything else you would like to share. Jake and I, our goal here at the center is to really support you, if there are tools or resources mentioned here or not mentioned here, please follow-up, we'll make sure we get them to you.

>> We acknowledge it is a lot of information so if you need to follow-up with us directly to be triaged to the appropriate resource, we're glad to help.

We'll let people have a bit o break before switching over to the next session.

>> Just logistically, so you all stay on the video. Don't X anything out. You will automatically be funneled back into the main classroom. Don't do anything for that. You will hang up the conference line and then we will call back in like you did this afternoon at 1:00. We recommend that you use your phone as opposed to your computer mic and speakers. There will be opportunities for sharing during the closing session. We would love to hear from you without having audio related issues.

To give you a heads-up in to the last half hour, you may want I want to think -- you may want to think about one thing you would like to stop, one thing you would like to start doing and what will you continue to do. Those are -- that's what we'll ask folks to report out on. We'll give you 3 extra minutes for the wheels to turnabout that before we return to the general session in a couple of minutes.

Thank you all so much for joining us.

>> Thank you for your time and attention.

Look forward to staying in touch.

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